PUBLIC HEALTH, WELFARE & SAFETY
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Bill No. SB83

Testimony in Support of SB 83

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In the last year, the Legislative Audit Division conducted an audit of Montana's EMS system. One key finding of that audit was a recommendation that the Department *develop an objective, data-driven system evaluation and quality improvement oversight approach*.

To improve quality, there must be a commitment to a new strategy to attaining quality. The Department is supportive of SB 83 because it represents commitment to a modern approach to improving patient care. When an adverse event occurs, our agency typically finds itself reacting to a complaint, resulting in a response which seeks to close the case by disciplining an individual or EMS service. This "shame and blame" approach is ineffective for several reasons:

First, it ignores the fact that other factors in the system (besides the individual) might have contributed to, facilitated, or even caused the adverse event. Much of emergency care, especially in rural Montana, represents good people, trying to do good things, with limited information and resources. SB 83 helps opportunities for improvement to be identified and modified, thereby reducing the chances of future adverse events.

Second, focusing blame on the individual doesn't prevent the same event from happening to another individual in the future. Industries such as aviation have positive safety records because they look at factors in the system which may have contributed to a crash, not just the pilot's actions. SB 83 helps the provider becomes invested in the process and become part of a solution which then helps someone else in a similar incident in the future.

Third, the "shame and blame" mentality creates a culture where providers fear of reprisal and may try to hide adverse events. A performance improvement system invests the provider in a 'non-punitive' approach to reviewing and improving patient care. SB 83 helps the Department grow from a "just respond to complaints" approach to strategies which will attempt to reduce the number of complaints received and improve patient care.

Current emphasis on patient outcomes in many emergency care systems focuses on whether the patient lived or died. Tracking how many patients died from a cardiac arrest helps an ambulance service measure whether it is getting better or worse, but many times does nothing to help understand what is producing positive or negative performance.

SB 83 allows an EMS council – representatives of all partners to the patient's care - to study an entire event as a team. For example, review of a cardiac arrest may include:

- the **dispatcher** who answered the 91-1 call
- the **law enforcement officer** who was the first to arrive at the scene
- the **fire department quick response unit** who were the first to arrive with an AED
- the **basic life ambulance** who arrived next to treat the patient
- the **advanced life support ambulance** who further treated and transported the patient
- the **hospital** who received the patient

If the patient does not survive a cardiac arrest, everyone may each say "That was too bad, I wish there was something that could have made it better." Each in themselves knows something about this call and if they are able to sit together and review the 'chain of survival' in this case – known factors which help produce a positive outcome for a cardiac patient - they would review:

- whether the patient recognized their symptoms and called 9-1-1 immediately
- whether the family or others around the patient new CPR
- whether the dispatcher was trained in how to assess the patient over the phone and responds the right units as quickly as possible
- whether the first arriving law officer had an AED in his/her car
- whether the advanced life support ambulance was dispatched to rendezvous quickly
- whether the hospital knew the patient was arriving in enough time to be ready upon the patient's arrival

An EMS Council reviewing a cardiac case could be faced with several opportunities for improvement which would be lost without run reviews encouraged and protected under SB 83. For example, an EMS Council may observe - as a team – that law enforcement is often first on

the scene in their community. They then might find ways to get AEDs in law enforcement vehicles and get that critical link in the 'chain of survival' to the patient sooner.

SB 83 allows all partners in a patient's care to review – not in isolation but together as a team – a menu of activities which may affect a patient's outcome. Whether it's just one ambulance service and the hospital or multiple agencies and hospitals, SB 83 will improve patient outcomes in Montana.

We thank the interim committee and Senator Liable for sponsoring this bill and we stand in support of SB 83. We would appreciate your support also.

Thank you.